

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038641

FILED VS. OCT 18 1960

Primary Registration District No. 3026

Registrar's No. 487

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b life	c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 737 S. Main St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 737 S. Main St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle HILL Last GRINTER			4. DATE OF DEATH Month October Day 8 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1878	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Photographer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Near Lee's Summit Mo	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME P. H. Grinter			
13b. MOTHER'S MAIDEN NAME Mary Jones		14. NAME OF HUSBAND OR WIFE Sallie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-36-1512		17. INFORMANT Sallie Grinter Address Indep. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH Sudden Chronic Cerebral
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Feb 29, 1960 to Oct 8, 1960 and last saw her alive on Feb 29, 1960 Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE W. H. Nickerson M.D.		22b. ADDRESS 604 W. Maple Independence, Mo.		22c. DATE SIGNED 10/8/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Woodlawn	
24. FUNERAL DIRECTOR OTT & MITCHELL		25. DATE RECD. BY LOCAL REG. 10-10-60		26. REGISTRAR'S SIGNATURE James H. [Signature]	

(Licensed Embalmer's Statement on Reverse Side)

STATE FILE NUMBER

1. NAME OF DECEASED		2. DATE OF BIRTH		3. DATE OF DEATH	
4. PLACE OF BIRTH		5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. SEX		8. RACE		9. OCCUPATION	
10. MARITAL STATUS		11. EDUCATION		12. RELIGION	
13. SOCIAL SECURITY NUMBER		14. MOTHER'S MARRIAGE LICENSE NUMBER		15. MOTHER'S BIRTH DATE	
16. MOTHER'S BIRTH PLACE		17. MOTHER'S BIRTH DATE		18. MOTHER'S BIRTH PLACE	
19. MOTHER'S BIRTH DATE		20. MOTHER'S BIRTH PLACE		21. MOTHER'S BIRTH DATE	
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97. MOTHER'S BIRTH DATE		98. MOTHER'S BIRTH PLACE		99. MOTHER'S BIRTH DATE	
100. MOTHER'S BIRTH PLACE		101. MOTHER'S BIRTH DATE		102. MOTHER'S BIRTH PLACE	

0961-8-1-100

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by _____, Student Embalmer No. _____

working under my personal supervision:

Student _____
Signature of Student Embalmer _____

Signed _____

Licensed Embalmer No. 39

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.